Neuro Focus Center New Patient Mental Health Intake

Patient Data

Name: ______________________ Date: ______________

Address: ______________________

Phone: ______________ Email: ______________

DOB: __________ Age: __________ Sex: ____ Social Security #: ______________

Primary Physician: ______________________ Phone: ______________

Current Pharmacy: ______________________ Phone: ______________

Complaint

What is your major complaint? ______________________

Start Date: __________ Have you previously suffered from this complaint? __________

Previous therapist(s) seen for complaint: ______________________

Previous treatment for complaint: ______________________

Aggravating Factors: ______________________

Relieving Factors: ______________________

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐	☐

Family History

Did your parents divorce? Y / N If yes, how old were you? ______________

Family member medical conditions: ______________________

Family member mental conditions: ______________________

Early Development

Where were you born? ______________________

Who raised you? ______________________

How old were you when you left home? ______________________

Have any immediate family members died? __________ Who? __________

Have any committed suicide? __________ Who? __________

Describe any neglect you suffered, and by whom: ______________________

Trauma suffered and by whom: ______________________

Abuse suffered and by whom: ______________________

Highest education level completed:

Anything Else You Want the Doctor to Know

____

____

____

____

____

____

______________________ Patient/POA Signature

______________________ Date

As a new patient, please fill out the information below to the best of your ability

Medical History

Have you ever had the following (check all that apply):

Measles	☐	Mumps	☐	Chicken Pox	☐	Whooping Cough	☐
Scarlet Fever	☐	Diphtheria	☐	Smallpox	☐	Pneumonia	☐
Rheumatic Fever	☐	Heart Disease	☐	Arthritis	☐	Ulcers	☐
Venereal Disease	☐	Anemia	☐	Bladder Infections	☐	Epilepsy	☐
Migraine Headaches	☐	Tuberculosis	☐	Diabetes	☐	Cancer	☐
Polio	☐	Glaucoma	☐	Hernia	☐	Kidney Disease	☐
Blood Transfusions	☐	Back Trouble	☐	High/Low Blood Pressure	☐	Hemorrhoids	☐
Asthma	☐	Hives & Eczema	☐	AIDS or HIV	☐	Infectious Mono	☐
Bronchitis	☐	Stroke	☐	Hepatitis	☐	Thyroid Issues	☐

Previous Hospitalizations/Surgeries/Serious Illnesses:

Allergies:

Medications (including non prescription):

Have you ever tried any of the following? (check all that apply) :

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency/dates of use: ______

Have you ever been treated for drug/alcohol abuse? Y / N If yes, when? ______

For which substances? ______

Do you smoke cigarettes? Y / N If yes, how many per day? ______

Do you drink caffeinated beverages? Y / N If yes, how many per day? ______

Have you ever abused prescription drugs? Y / N If yes, which ones?

Neuro Focus Center, LLC

Financial Policy

Welcome to Neuro Focus Center, LLC. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policies.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information and any necessary referrals. Should your insurance require a referral, and we have not received it prior to your appointment, you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

This office bills only for services performed by the physicians and practitioners of Neuro Focus Center, LLC, which include but not limited to psychotherapy, medication management, and phone managements. Any laboratory, radiology, anesthesiology or hospital billings you may receive are separate entities and you must contact that entity or your insurance company if you have questions about additional services bills, regardless of whether the services were ordered by Neuro Focus Center,
LLC.

As a courtesy we will attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. **We ask that you notify us 48 business hours in advance to cancel and/or reschedule your appointment.** ***Please be aware that failure to do so may result in a missed appointment fee of $75.00, which is not billable to or covered by your insurance.***

It is your responsibility to inform this office of any/all changes in your name, address, phone number and insurance coverage.

Delinquent accounts will be turned over to an outside collection agency if unpaid after 60 days without further notice. In the event that your account is turned over for collections, you are responsible for all associated collection, court and attorney costs.

Neuro Focus Center, LLC accepts Visa, MasterCard and Discover cards. ***We do not accept personal checks.***

I have read the Financial Policy. I understand and agree to these terms.

____
Print name

______________________________ ______________
Signature date

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practice for Neuro Focus Center, LLC ____________
Please initial

NEURO FOCUS CENTER, LLC

Consent to Treatment and Recipient's Rights

I, ______________________________ the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Neuro Focus Center, LLC, hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party.

Recipient's Rights: I certify that I have received the Recipient's Rights form and certify that I have read and understand its content.

Non-voluntarily Discharge from Treatment: A patient may be terminated from the Center non-voluntarily if: (A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the center, and/or (B) the patient refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Patient Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by federal and/or state law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related patient records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the patient's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the patient, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Patient data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Neuro Focus Center, L.L.C.

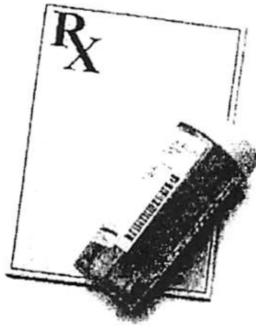
______________________________ ______________

Signature of Patient/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

______________________________ ______________

Patient Name Date



Neuro Focus Center

Prescription Refill Policy

As a patient, you hold primary responsibility for your medications. If your controlled substance/narcotic medications are lost, misplaced or stolen you will not be given a replacement.

Medication refills are made by your physician on designated days. Please plan ahead. Refills cannot be made by your physician, at night or on weekends or holidays. Refill authorizations can take up to 5 business days so you are urged to call ahead for refills.

You should always keep track of the number of pills remaining. If your medication runs out sooner than prescribed, you will be unable to get another prescription before the due date for the next prescription.

Thank you for choosing Neuro Focus Center. We look forward to working with you to assure safe and high quality medical care.

By signing below, I acknowledge that I have read these policies, understand these policies, and agree to abide by them fully.

____________________________________ Patient's signature Date

____________________________________ Patient's name (printed Date

NEURO FOCUS POLICIES:

1. **PAYMENTS:**

• When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not make payment on a claim and that it will be the Patient's/Guardian's responsibility to do so.

2. **CO-PAYS, CO-INSURANCE and DEDUCTIBLES:**

• All Co-Pays are due at the time of today's appointment prior to seeing the doctor.

• Account balances are to be paid in full at the time of today's appointment prior to seeing the doctor.

• Deductibles, Co-insurance and any additional charges will be collected at the time of check out. You are ultimately responsible for payment of charges for services from our office.

• It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit.

• If your plan requires a referral, it is your responsibility to obtain this prior to being seen.

• It is our desire to help you as much as possible with claims that are submitted to your insurance company. However, you are responsible for any unpaid claim by your insurance.

• Unpaid previous balances must be paid in full prior to any additional visits, • Returned check fee is $25.00. *

• The Patient will be responsible for all Attorney Fees, Legal Fees and Court Cost if the account is turned over to collections.

• If the Patient is a minor the Patient's Legal Guardian will be responsible for all Attorney Fees, Legal Fees and Court Cost if the account is turned over to collections.

3. **CANCELLATIONS/NO SHOWS:**

• When an appointment is scheduled, that time has been set-aside for you and when it is missed, that time cannot be used to treat another patient.

• Cancellations for appointments must be received 48 hours prior to the scheduled appointment. You may leave a 24-hour cancellation message with our answering service.

• Patients who fail to keep or cancel a scheduled appointment will be charged a $75.00 No-Show/No-Call Fee. This fee must be paid before re-scheduling appointment.

Please note that insurances, including Medicare do not cover this fee.

(We make reminder calls as a courtesy, but it is your responsibility to keep track of your appointment).

New Patients:

• 1st No Show – Office will notify patient by phone call and remind he/she of the missed appointment and No Show policy.

• 2nd No Show – The chart will be deactivated indicating termination of services.

Established Patients:

• 1st No Show – Office will call patient to remind he/she of missed appointment and No Show policy. A $75.00 fee will be assessed and must be paid before re-scheduling appointment.

• 2nd No Show – A $75.00 fee will be assessed and must be paid before re-scheduling appointment. Office will notify patient by mailing a letter and policy reminder.

• 3rd No Show – Office will notify patient by mailing a final letter indicating termination of services. Termination of service will include a grace period of 30 days for prescription refills.

It will be the patients' responsibility to find a new physician and contact his/her insurance carrier for assistance with finding another physician.

4. MEDICAL RECORDS/PSYCHIATRY NOTES:

- Medical Records request must be received at least 7-10 business days prior to the date needed.
- There is a non-refundable fee of $25.00 for requested copies of medical records.
- **WE DO NOT FAX MEDICAL RECORDS TO PATIENTS OR FAMILY Members.**
- Fees must be paid prior to mailing or pick up of medical records.

5. REFUNDS: (Pertain to Insurances Only)

- An insurance company has Ninety Days to process your claim. Even after the Ninety Days the insurance company may still be processing your claim.
- Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, upon request a refund check will be issued within 30 days.

7.STATEMENTS:

- Your statement is mailed to you the first week of the month.
- If you do not have a balance, you will not receive a statement.

By signing you fully understand the above policy.

Signature of Patient/Guardian:_________________________________ Date:___________